

**PRESUMPTIVE ELIGIBILITY
NOTICE OF DECISION**

Hospital's Name _____ Case Manager _____

Applicant's Name _____ Billing No. _____

Applicant's Date of Birth _____

On _____, Medicaid benefits for the Presumptive Eligibility application dated _____ were:
Month/Day/Year Month/Day/Year

☐ Approved effective _____ ending effective _____
Month/Year Month/Year

☐ Denied

Reason for Denial:

- ☐ The applicant does not meet citizenship requirements.
- ☐ The applicant is not a Nevada resident.
- ☐ The applicant's income is above the Federal Poverty Limit.
- ☐ The applicant is receiving Medicaid through another category of assistance.
- ☐ The applicant has received Presumptive Eligibility within the last 2 years.
- ☐ Other _____

COMMENTS: _____

Case Manager Signature _____ Date _____

Individuals determined eligible for Presumptive Eligibility are entitled to benefits from the date the hospital determined them presumptively eligible until:

- the day a DWSS eligibility determination is made on a full Medicaid application; or
- when an application for Medicaid has not been filed, the last day of the month following the month the determination of presumptive eligibility was made.

You must submit an Application for Medical Assistance to the Division of Welfare and Supportive Services prior to the end of the Presumptive eligibility period. You can apply online or obtain an application at dwss.nv.gov.

This notice may be used as proof of medical assistance eligibility for 10 days from the date of approval. A Medicaid/Nevada Check-Up card will be mailed to you. The eligible member must show their card or notice to the doctor, pharmacist, hospital or other medical care provider as proof of medical assistance eligibility.

The determination of Hospital Presumptive Eligibility does not provide the right to an appeal or hearing. If you disagree with the decision made you must complete a Medicaid application.